Hospice Care Eligibility Determination Letter

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

City, State, Zip: [Insert City, State, Zip]

Dear [Insert Patient Name / Family Member's Name],

We are writing to inform you about the determination of hospice care eligibility for [Insert Patient Name]. After a thorough evaluation of the patient's medical condition, we have concluded the following:

Eligibility Criteria

- Diagnosis: [Insert Chronic Disease Diagnosis]
- Progression of Illness: [Brief Description of Progression]
- Life Expectancy: [Insert Expected Life Span, e.g., 6 months or less]
- Patient/Family Goals: [Insert Goals of Care]

Based on these criteria, [Insert Patient Name] is eligible for hospice care services. Our team is committed to providing compassionate care and support to both the patient and family during this time.

Please feel free to reach out to our office at [Insert Phone Number] or [Insert Email Address] if you have any questions or need further assistance.

Sincerely,

[Insert Provider Name]

[Insert Title]

[Insert Hospice Organization Name]

[Insert Hospice Organization Address]

[Insert Hospice Organization Phone Number]